MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25-a)

12369

CERTIFICATE OF DEATH

★ Reg. Diat. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Edgewood Arsenal, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 days

Hospital, Institution, or street address where death occurred:

Station Hospital

How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Edgewood

(If outside city or town limits, write RURAL and give nearest town)

Street No. Edgewood Heights

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: ADAMS, Viola C.

3. (b) Social Security Number: — —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Married

6.(b) Name of husband or wife: John W. Adams

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): 15 May 1921

8. AGE: Years	Months	Days	If less than one day
24	6	19	..... hrs. ..... min.

9. Birthplace: Toccoa, Georgia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Matthew Brown

FATHER — 13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Mamie Webb

MOTHER — 15. Birthplace: Westminster, South Carolina

16. Informant: Mother

Address: Niagara Fall, New York

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 7/45 (month) (day) (year)

Cemetery or crematory: Oakwood

Location: Niagara Falls N.Y.

18. Funeral director: Dean & Falls

Address: Bel Air Md

19. 12-5 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 December 19 45, at 10.59 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 November 19 45, to 4 December 19 45

and that I last saw h... or alive on 4 December 19 45

Immediate cause of death	DURATION
Liver, acute yellow atrophy of, severe, cause undetermined	24 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: confirm diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

HARRY WEINTRAUB, Capt, MC

23. SIGNATURE: Harry Weintraub M. D. or other

Address: Station Hospital Edgewood Arsenal Md Date signed: 12/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

THIS CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12370

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred: St. Francis Villa
How long in hospital or institution? 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Commerce & Market
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dr. Mary William (Margaret Barry)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 2 - 1896

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
49	10	10		

9. Birthplace: South Amboy N. J.
(Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business: —

FATHER
12. Name: Nicholas Barry
13. Birthplace: U. S. A.

MOTHER
14. Maiden name: Mary Jane Teague
15. Birthplace: U. S. A.

16. Informant: Hosp. Records
Address: Commerce & Market

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/14/45 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Baltimore

18. Funeral director: Cunningham & Dor
Address: Havre de Grace

19. Dec. 13 1945 (Date rec'd by registrar) C. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 12 19 45, at 2:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 45 to Dec 12 19 45
and that I last saw h alive on Dec 12 19 45

Immediate cause of death	DURATION
Carcinoma Stomach	
Due to: Carcinomatosis	
Due to:	
Other conditions: Cachexia	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M. D.
M. D. or other
Address: [illegible] Date signed: 12/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 578 K

CERTIFICATE OF DEATH

★ Reg. Dist. No. 1271 18 S.

1. PLACE OF DEATH:
County: Harford.
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or Institution? 10 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. 114 N. Phila. Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Isaac W. Bayless

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Nina S. Osborn
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): April 15, 1858

8. AGE: Years	Months	Days	If less than one day
87	8		hrs. min.

9. Birthplace: Aberdeen Harford Co. Md.
(Town, county, and state)
10. Usual occupation: Canner
11. Industry or business: Retired

FATHER
12. Name: Samuel Bayless
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Elizabeth Botts
15. Birthplace: Harford Co. Md.

16. Informant: Mrs. Isaac W. Bayless
Address: 114 N. Phila. Blvd.

17. Burial — Date thereof: Dec. 18, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Presbyterian Chapel
Location: Near Aberdeen
18. Funeral director: Henry Tarring & Sons
Address: Aberdeen, Md.

19. Dec. 19 1945 A. L. Lima M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 15 1945, at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1943 to Dec 15 1945 and that I last saw h..im alive on Dec 15 1943

Immediate cause of death	DURATION
Urinary retention	
Due to: Carcinoma of Prostate	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G B Jamison M.D.
M. D. or other
Address: Aberdeen Md Date signed: 12-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for addition of approximate age of deceased is shown on FILM No. I 00 JAN 18 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (MSB)

CERTIFICATE OF DEATH

12372

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Unknown
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: North Carolina County:
City or town: Rocky Mount
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 424 Normal St
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #2 ✓

3. (a) FULL NAME: Matthew L Blue

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Unknown

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
33	Unknown		hrs. min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business: Aberdeen Proving Ground

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Bell Blue
15. Birthplace: Rocky Mount N.C.

16. Informant: State Trooper
Address: Conowingo Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 17-1945 (month) (day) (year)
Cemetery or crematory: Rocky Mount N.C.
Location: Rocky Mount N.C.

18. Funeral director: Henry Funeral Home
Address: Aberdeen Md.

19. Dec. 14 1945 (Date rec'd by registrar) Nellie H Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10 1945 at 8A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Carbon monoxide poisoning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 12/10/45
Where did injury occur? Home de Grace Harford Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Automobile
Means of injury: Fell asleep in car Injured at work? no

23. SIGNATURE: Gerald C Palmer M.D.
Deputy Medical Examiner Harford County
M. D. or other
Address: Bel Air, Md. Date signed: 12/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12373

& THIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

Reg. Dist. No. 18-

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Harford Memorial Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frances N. Boyd

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife George L. Boyd
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1890

8. AGE: Years	Months	Days	If less than one day
55	10	19	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. Name of FATHER Frank Ryan
13. Birthplace of FATHER Maryland
14. Maiden name of MOTHER Kate Jackson
15. Birthplace of MOTHER Maryland
16. Informant George Boyd — Husband
Address Perryville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 17, 1945 (month) (day) (year)
Cemetery or crematory Asbury
Location Port Deposit, Md. Rural.
18. Funeral director Lee A. Patterson & Son
Address Perryville, Md.
19. Dec. 17 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1945; 10:20 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1, 1945, to Dec 17, 1945
and that I last saw h[illegible] alive on Dec 14, 1945

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to Diabetes Mellitus	
Due to Diabetic Coma	
Other conditions T. Dyemia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D.
M. D., or other
Address Havre de Grace Md. Date signed 12/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-0)

12374

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GRAYSON EDWARD BRADENBAUGH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 9, 1945

8. AGE: Years | Months: 6 | Days: 20 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Jarrettsville Har. Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Albert F. Breidenbaugh
13. Birthplace: Jarrettsville

MOTHER
14. Maiden name: Ruth N. Carr,
15. Birthplace: Belmar, Balto Co. Md.

16. Informant: Albert F. Breidenbaugh
Address: White Hall, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2, 1946 (month) (day) (year)
Cemetery or crematory: Jarrettsville
Location: Jarrettsville Md.

18. Funeral director: Martin L. Kurtz
Address: Jarrettsville, Md.

19. Jan 2 1946 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 1945, at 11 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29 19 Yr. to Dec. 30 19 Yr. and that I last saw h... alive on Dec. 30 19 Yr.

	DURATION
Immediate cause of death: Myocarditis	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. M. France M. D. or other
Address: Parkton, Md. Date signed 1/3/1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-1A15

12375

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 30 years
Hospital, Institution, or street address where death occurred:
317 So. Stokes Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 317 So. Stokes St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Robert Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Tillian Brown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 7, 1876

8. AGE: Years: 69 | Months: X | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Harford County Maryland
(Town, county, and state)

10. Usual occupation: Railroad Employee

11. Industry or business

FATHER
12. Name: Zechariah Brown
13. Birthplace: Harford County

MOTHER
14. Maiden name: Cesie Tolite
15. Birthplace: Harford County

16. Informant: Mrs. Tillian Brown
Address: 317 So. Stokes Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 13 45 (month) (day) (year)
Cemetery or crematory: St. James Cemetery
Location: Havre de Grace, Md.

18. Funeral director: Elmer E. Bullock
Address: 56 Lewis St. Havre de Grace, Md.

19. Dec. 13 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registror

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10 1945 at 5:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-29- 1944, to 12-10- 1945 and that I last saw him alive on 12-10- 1945

Immediate cause of death	DURATION
Chronic myocarditis	12.29.44
Due to: mutal Intoffecency	12-10-45
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Claude L Dawson M. D. or other
Address: Havre de Grace Date signed: 12-12-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

P 378

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94(a)

CERTIFICATE OF DEATH

Reg. Dist. No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Joppa
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Magnolia Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Joppa
(If outside city or town limits, write RURAL and give nearest town)
Street No. Magnolia Rd
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #1

3.(a) FULL NAME: Daniel Isaac Bunch

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marie M. Bunch

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 27th 1896

8. AGE: Years	Months	Days	If less than one day
49	9	19	..... hrs. ..... min.

9. Birthplace: Oaktown Indiana
(Town, county, and state)

10. Usual occupation: Die Maker

11. Industry or business: Edgewood Arsenal

FATHER
12. Name: Willis Bunch
13. Birthplace: Unknown

MOTHER
14. Maiden name: Cora Bland
15. Birthplace: "

16. Informant: Marie M. Bunch (Wife)
Address: Magnolia Rd. Joppa, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/20/45 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Balto. Md.

18. Funeral director: William Cook Inc.
Address: 1217 St Paul St

19. 12/18/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 19 45, at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Gerald C. Palmer MD
Deputy Medical Examiner
Harford County Md.
M. D. or other
Address: Bel Air, Md. Date signed 12/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (36)

CERTIFICATE OF DEATH

12377

Reg. Dist. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Upper X Roads
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Upper X Roads
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Cochran

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances Elizabeth Cochran
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): May 8, 1865

8. AGE: Years	Months	Days	If less than one day
80	7	10	..... hrs. ..... min.

9. Birthplace: Upper X Roads, Harford Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer (retired)
11. Industry or business

FATHER
12. Name: Maurice Cochran
13. Birthplace: Ireland

MOTHER
14. Maiden name: Bridget Kelly
15. Birthplace: Ireland

16. Informant: Howard L. Cochran
Address: 2708 Huntington Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21, 1945 (month) (day) (year)
Cemetery or crematory: St. Johns
Location: Long Green, Md.

18. Funeral director: Martin G. Kurtz
Address: Jarrettsville, Md.

19. Dec. 21 1945 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18 1945; at 3 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 15 1945, to Dec. 18 1945, and that I last saw h- alive on Dec. 17 1945.

	DURATION
Immediate cause of death: Bronchopneumonia	2 days
Due to: Cerebral Hemorrhage	5 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford T. Gladson, M.D.
M. D. or other
Address: Fork, Md. Date signed: 12/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

752

Reg. Dist. No. 12185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 611 Otsego
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth B. Currier

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Theodore W. Currier
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 29, 1854

8. AGE: Years	Months	Days	If less than one day
90	11	28	..... hrs. ..... min.

9. Birthplace: Lancaster Co., Pa.
(Town, county, and state)
10. Usual occupation: School Teacher
11. Industry or business

FATHER
12. Name: Christian Newswanger
13. Birthplace: Lancaster Co., Pa.

MOTHER
14. Maiden name: Unknown
15. Birthplace

18. Informant: Mrs Carrie Eaton
Address: 620 Otsego St. Havre de Grace Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 29, 45 (month) (day) (year)
Cemetery or crematory: Angel Hill Cemetery
Location: Havre de Grace, Md.

18. Funeral director: Lee A Patterson & Son
Address: Perryville, Md.

19. Dec. 28 19 45 — A. L. Lewis M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 19 45, at 7 20 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 19 45, to Dec 26 19 45
and that I last saw h. alive on Dec 26 19 45

Immediate cause of death	DURATION
Cardiac insufficiency	
Due to (Senility)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: A. L. Lewis M.D.
M. D. or other
Address: Havre de Grace Md. Date signed 12-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

12379

Reg. Diat. No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town Street
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Street
(If outside city or town limits, write RURAL and give nearest town)
Street No. 120
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles D. Davis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Corinne Davis
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 9 1876

8. AGE: Years	Months	Days	If less than one day
69	9	22	...hrs. ...min.

9. Birthplace Harford Co Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farming
FATHER 12. Name George Davis
13. Birthplace Harford Co Md
MOTHER 14. Maiden name Martha Wallace
15. Birthplace Harford Co Md
16. Informant Rutland Davis
Address Baltimore Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 3 1946 (month) (day) (year)
Cemetery or crematory Kimblehead
Location Street Md
18. Funeral director H. Howard Nett
Address Fawn Grove Pa
19. Jan 3rd 1946 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 19 45 at 2.00 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8 19 45 to December 26 19 45
and that I last saw him alive on December 26 19 45

Immediate cause of death	DURATION
Coronary occlusion	
Due to Coronary Condition	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Benjamin Dorsey M.D.
M. D. or other
Address Cardiff Md Date signed 1-1-46

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5722)

12380

CERTIFICATE OF DEATH

★ Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 122 N. Stokes St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Paula Dubree

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 26 - 1945

8. AGE: Years | Months | Days: 1 | If less than one day: ..... hrs. 0 min.

9. Birthplace: md. (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business

FATHER
12. Name: Walter Stout
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Katherine Dubree
15. Birthplace: Perryman, md.

16. Informant: Hosp. Records
Address: Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/26/45 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace, Md.

18. Funeral director: Lemmon and Son
Address: Havre de Grace, Md.

19. 12-26 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26th 1945, at 2:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 25 1945, to Dec 26 1945
and that I last saw h.. alive on Dec 26 1945

	DURATION
Immediate cause of death: Patent Foramen Ovale	1 day
Due to: Prematurity	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Havre de Grace Date signed 12/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12381

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93 D)

CERTIFICATE OF DEATH

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Short Line
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Carrie V. Elliott

3.(b) Social Security Number: 214-10-0353

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John W. Elliott

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): July 10 - 1896

8. AGE: Years	Months	Days	If less than one day
49	5		hrs. min.

9. Birthplace: Aberdeen Harford Co. Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: home

FATHER
12. Name: James Singleton
13. Birthplace: Harford Co Md

MOTHER
14. Maiden name: Mary Jamason
15. Birthplace: Harford Co. Md

16. Informant: Mrs. John W. Elliott
Address: Aberdeen Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 24 - 1945 (month) (day) (year)

Cemetery or crematory: Bakers

Location: Aberdeen Md

18. Funeral director: Henry Jamason Sons

Address: Aberdeen Md.

19. Dec 24 19 45 (Date rec'd by registrar) Nellie H Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 23rd 1945 at 12:35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23 1945, to Dec 22 1945 and that I last saw h.. alive on Dec 10 1945

Immediate cause of death	DURATION
Chronic Passive congestion	9 yrs
Due to Hypertensive cardiovascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: G B Jamison MD
M. D. or other

Address: Aberdeen Md Date signed 12-23-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12382

Reg. Dist. No. 18-018

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen Proving Ground, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 516 Maiden Choice Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FOY, WALTER Joseph

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mrs. Susan Foy
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 3, 1916

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
29 29	8	10		

9. Birthplace: Scranton Pa
(Town, county, and state)
10. Usual occupation: Soldier U. S. Army
11. Industry or business:
FATHER 12. Name: Dommnic Defasci (Foy)
13. Birthplace: Russia
MOTHER 14. Maiden name: Amelia Nowtinski
15. Birthplace: Lithuania
16. Informant: Mrs Thos J Kenny
Address: 1600 Hollins St, Baltimore Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 15 1945 (month) (day) (year)
Cemetery or crematory: London Park Cemetery
Location: Baltimore Md
18. Funeral director: Howard K. McCormack
Address: Abingdon Md
19. Dec 15 1945 (Date rec'd by registrar) Marie M. Mockabee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 December 19 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Burn, severe, scalp, skin and muscle of back, arms, legs and lower quadrants of abdomen.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward T. Kasmir
EDWARD T. KASMIR Capt., MC M.D. or other
Address: Sta Hosp, Aberdeen Prov Ground, Md. Date signed: 14 Dec 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

12383

Reg. Diat. No. 185

WITHIN CORPORATE LIMITS OF

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 701 Ontario, St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 701 Ontario St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bertie Whitcomb Gibson

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Hugh B. Gibson — 6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Aug. 19, 1868

8. AGE: Years	Months	Days	If less than one day
77	4	24	— hrs. — min.

9. Birthplace: H. Co. Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: House Duties

FATHER
12. Name: John Whitcomb
13. Birthplace: Md.

MOTHER
14. Maiden name: Henrietta Jones
15. Birthplace: Md.

16. Informant: Mrs. Ruth H. Gibson
Address: Havre de Grace Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 16, 1945 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace
18. Funeral director: T. Madison Mitchell
Address: Havre de Grace Md.

19. Dec. 15 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 13 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to Dec. 13 1945 and that I last saw h-er alive on Dec. 13 1945

Immediate cause of death	DURATION
Cardiac Insufficiency	
Due to Chronic Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. L. Lewis M.D. M. D. or other
Address: Havre de Grace, Md. Date signed 12-15-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12384

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, Institution, or street address where death occurred:

St. Francis Villa

How long in hospital or institution? 1 yr.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. Commerce & Market

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sr. M. Leontina (Marie Quentensberger)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 26 1867

8. AGE:

Years	Months	Days	If less than one day
78	10	20	..... hrs. ..... min.

9. Birthplace Switzerland (Town, county, and state)

10. Usual occupation Cook

11. Industry or business

FATHER 12. Name Vincent Quentensberger

FATHER 13. Birthplace Switzerland

MOTHER 14. Maiden name Frances J.

MOTHER 15. Birthplace Switzerland

16. Informant Hosp. Records

Address Commerce & Market

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/18/45 (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Baltimore Md.

18. Funeral director Pennington & Son

Address Havre de Grace, Md

19. 12-17 19 45 A. L. Levin M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 19 45 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 45 to Dec 15 19 45

and that I last saw h.... alive on Dec 15 19 45

Immediate cause of death	DURATION
Uremia Cachexia	
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other conditions Cataract	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D. M.D. or other

Address Havre de Grace Md Date signed 12/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

12385

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County: Harford

City or town: Edgewood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Nora L. Handschue

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife: Ralph Handschue

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 3, 1898

8. AGE: Years	Months	Days	If less than one day
47	9	17	hrs. min.

9. Birthplace: Seven Valleys Penna. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Jacob Kohler

FATHER — 13. Birthplace: Penna.

MOTHER — 14. Maiden name: Lilley Copp

MOTHER — 15. Birthplace: Penna.

16. Informant: Ralph Handschue

Address: Edgewood Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 22, 1945 (month) (day) (year)

Cemetery or crematory: Goodling Funeral Home

Location: Seven Valleys Pa.

18. Funeral director: Howard K. McComas & Son

Address: Abingdon Md.

19. Dec 21 1945 (Date rec'd by registrar) Marie M. Medchill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 1945, at 5: P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1945, to Dec 20 1945

and that I last saw h... alive on Dec 20 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days.
Due to: Cardio-renal Hypertension Disease	5 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Ralph Hurley M.D. M. D. or other

Address: Churchville Md. Date signed: Dec 24

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

WITHIN CORPORATE LIMITS OF

2411 N. Charles St., Baltimore (33a)

12385

CERTIFICATE OF DEATH

Reg. Diet. No. 185

1. PLACE OF DEATH:
County Harford Co
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 302 Juniata St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 302 Juniata St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Vera Mae Harkeness

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1925

8. AGE: Years	Months	Days	If less than one day
20	9	23	— hrs. — min.

9. Birthplace Havre de Grace Md. (Town, county, and state)
10. Usual occupation Home Duties
11. Industry or business

FATHER
12. Name James J. Harkeness
13. Birthplace Md.

MOTHER
14. Maiden name Mildred Eleg. Nicholas
15. Birthplace Md

16. Informant Mrs. James J. Harkeness
Address Havre de Grace Md.

17. Burial Date thereof Dec. 19 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace, Md.

18. Funeral director P. Madison Mitchell
Address Havre de Grace Md.

19. Dec. 18 19 45 C. L. Lewis M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 19 45 at 2 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 11 19 45 to Dec. 17 19 45
and that I last saw her alive on Dec. 17 19 45

Immediate cause of death: Pulmonary Oedema — DURATION: few hours
Due to: Viral pneumonia — 1 Day
Due to: La Grippe
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Emily Corbett M.D.
M. D. or other
Address Havre de Grace Date signed Dec 18 19 45

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

* WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

12387

★ Reg. Dist. No. 18-

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No. Churchville

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Winfield R. Hawkins

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Lida C. Workam

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 19 - 1864

8. AGE: Years	Months	Days	If less than one day
81	3		hrs. min.

9. Birthplace: Harford Co. Md. (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Retired

FATHER 12. Name: Philip Hawkins

13. Birthplace: Harford Co. Md.

MOTHER 14. Maiden name: Elizabeth Jarrett

15. Birthplace: Harford Co. Md.

16. Informant: Mrs. Winfield R. Hawkins

Address: Aberdeen Md. R.F.D.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 4 - 1945 (month) (day) (year)

Cemetery or crematory: Smith Chapel

Location: Churchville Harford Co. Md.

18. Funeral director: Henry Tarring Sons

Address: Aberdeen Md.

19. Dec. 3 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 1 1945 at 11:30 ~~A.M.~~ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1941 to Dec 1 1945; and that I last saw him alive on Dec 1 1945

Immediate cause of death	DURATION
Chr. Pernic Angina	3 days
Due to Arteriosclerotic C-V. Disease	4 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ralph Hurley M.D. M.D. or other

Address: Churchville Md. Date signed: Dec 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

12388

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:
County Harford
City or town Edgewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W Va County Hardy
City or town Wardensville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) ✓
2.(a) If veteran, name war

3.(a) FULL NAME Martha Ellen Heishman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Abraham Lincoln Heishman
6.(c) If alive, give age 82 years
7. Birth date of deceased (mo., day, yr.) Aug. 28 1871

8. AGE: Years	Months	Days	If less than one day
74	3	11	...hrs. ...min.

9. Birthplace High View W. Va.
(Town, county, and state)
10. Usual occupation School Teacher, retired
11. Industry or business

FATHER
12. Name Spaid
13. Birthplace unknown

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant Abraham L. Heishman
Address Wardensville W. Va.
17. Removal Date thereof Dec 11 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory G. L. Burdette, Funeral Director
Location Baker, W. Va
18. Funeral director Howard K. McCormack
Address Abingdon Md
19. Dec 11 1945 Marie M. Mood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1945 at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-19 1945 to to 12-9 1945 and that I last saw her alive on 12-9 1945

Immediate cause of death	DURATION
Chronic glomerulo nephritis	?
Due to	
Due to	
Other conditions peptic ulcer	3 mo

(Include pregnancy within 3 months of death)

Major findings of operations ✓ Date of op.
Autopsy results ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Fred O Hodson MD
M. D. or other
Address Edgewood Md Date signed 12-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-C)

CERTIFICATE OF DEATH

12389

★ Reg. Dist. No. 185-

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, Institution, or street address where death occurred:
Harford Memorial Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. # 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Annie Verdie Hughes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

8.(b) Name of husband or wife Carrol T. Hughes (deceased)
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 22, 1872

8. AGE: Years	Months	Days	If less than one day
73	4	15	..... hrs. ..... min.

9. Birthplace Aberdeen, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John Ames Greenland
13. Birthplace Md.

MOTHER
14. Maiden name Cornelia Andrews
15. Birthplace Md.

16. Informant Miss. Thelma Hughes
Address Aberdeen Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 9. 1945 (month) (day) (year)
Cemetery or crematory Bakers
Location Aberdeen Md.

18. Funeral director Henry Tanney Sons.
Address Aberdeen Md.

19. Dec. 7 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1945 at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 1945 to Dec 6 1945 and that I last saw h.. alive on Dec 6 1945

Immediate cause of death	DURATION
Cardiac Insufficiency	
Due to Boat Operation	
Due to Multiple Abdominal Adhesions - Partial obstruction	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Multiple adhesions Partial obstruction Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. Lewis M.D. M. D. or other
Address Havre de Grace, Md. Date signed Dec 7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12390

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Harford

City or town: Aberdeen Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Catherine E Jennings

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Solomon F Jennings

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 10 1862

8. AGE: Years	Months	Days	If less than one day
83			..... hrs. ..... min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Isam Edwards

FATHER — 13. Birthplace: N.C

MOTHER — 14. Maiden name: Lennie Hackler

MOTHER — 15. Birthplace: Va

16. Informant: Mrs. Fred Jennings

Address: Aberdeen, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 26 / 45 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Fountain Green

18. Funeral director: Deaver Bates

Address: Belair Md

19. 12/24/45 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 23 1945, at 11 30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Arteriosclerotic C V Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Gerald C Palmer M.D. Deputy Medical Examiner Harford County M. D. or other

Address: Belair, Md Date signed: 12/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12391

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: A Gingdon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: A Gingdon Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(n) If veteran, name war

3. (a) FULL NAME: Soloman F Jennings

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(n) Single, married, widowed, or divorced
M	W	W

B.(b) Name of husband or wife: Catherine F Jennings
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 8 - 1855

8. AGE: Years	Months	Days	If less than one day
90			..... hrs. ..... min.

9. Birthplace: Va
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Soloman Jennings
13. Birthplace: Va.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Va

16. Informant: Mrs Fred Jennings
Address: A Gingdon, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Jany 2 / 46
(month) (day) (year)
Cemetery or crematory: Mt Zion
Location: Fountain Green

18. Funeral director: Deaver Inlow
Address: Bel Air Md

19. 1-1 1946 Priscilla Fawood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 30 1945, at 6 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Arteriosclerotic C V Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Gerald C Palmer M D
Deputy Medical Examiner
Harford County
M. D. or other
Address: Bel Air, Md Date signed 12/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

12392, 18

Reg. Dist. No. 184

1. PLACE OF DEATH:

County Harford

City or town Whiteford Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Whiteford Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carrie Preston Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Thomas J. Jones

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 6 - 1871

8. AGE: Years	Months	Days	If less than one day
74	11	16	..... hrs. ..... min.

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER — 12. Name Hiram Jones

13. Birthplace Harford Co. Md.

MOTHER — 14. Maiden name Margaret J. Wright

15. Birthplace Harford Co. Md.

16. Informant Mrs. Ray Cantler

Address Whiteford, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 24th 1945 (month) (day) (year)

Cemetery or crematory Slate Ridge cemetery

Location Delta, Pa.

18. Funeral director Hubert P. Harkins

Address Delta Pa.

19. Dec 22 1945 (Date rec'd by registrar) M. McKirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1945 at 6 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10 1945 to December 22 1945 and that I last saw h alive on December 22 1945

Immediate cause of death	DURATION
cerebral Hemorrhage	
Due to Sclerosis of Heart	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Benjamin O. Mills M.D. or other

Address Cordell Md Date signed 12-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

12393

CERTIFICATE OF DEATH

Reg. Dist. No. 184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Darlington Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Darlington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 2

3.(a) FULL NAME: David B. Kenly

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 30 ~~1940~~ 1900

8. AGE:

Years	Months	Days	If less than one day
45	11	9	..... hrs. ..... min.

9. Birthplace: Harford Co., Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Plumbing
FATHER 12. Name: Richard Kenly
FATHER 13. Birthplace: Harford Co. Md
MOTHER 14. Maiden name: Margaret Hopkins
MOTHER 15. Birthplace: Harford Co. Md
16. Informant: Mrs. Margaret Kenly
Address: Darlington, Md. Rural
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 12 1946 (month) (day) (year)
Cemetery or crematory: Boranna Cem.
Location: Harford Co. Md.
18. Funeral director: H. S. Bailey
Address: Darlington, Md.
19. Dec. 10, 1946 (Date rec'd by registrar) M. D. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9 1945 at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gerald C. Palmer M.D.
DEPUTY MEDICAL EXAMINER
HARFORD COUNTY
M. D. or other
Address: Bel Air, Md. Date signed 12/10 1945

12892

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-b

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:
County Harford
City or town Churchville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Churchville
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Churchville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Chapman Kimble — 3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Eliz. Kimble
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Nov. 6, 1890

8. AGE:

Years	Months	Days	If less than one day
55	1	25	— hrs. — min.

9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual occupation: Farmer - Carpenter
11. Industry or business: Retired.

FATHER
12. Name: Frank C. Kimble
13. Birthplace: Md.

MOTHER
14. Maiden name: Sarah Rebecca Griffin
15. Birthplace: Md.

16. Informant: Mrs. Mary Elizabeth Kimble
Address: Churchville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3, 1945 (month) (day) (year)
Cemetery or crematory: Spesutia
Location: Harford Co. Md.
18. Funeral director: T. Madison Mitchell
Address: Havre de Grace, Md.

19. Jan 2 19 46 (Date rec'd by registrar) Britta B. Wright Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 31 19 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 39, to Dec. 31 19 45
and that I last saw h[illegible] alive on Dec. 31 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Coronary Thrombosis	5 hrs.
Due to Arteriosclerotic C.V. Disease	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Ralph Hydorn M.D. or other
Address: Elmwood Rd. Date signed Jan. 6

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (928)

CERTIFICATE OF DEATH

12394

★ Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred:
St. Francis Villa
How long in hospital or institution? 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. Commerce & Market
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Dr. M. Adolphine (Helen Klein)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 19-1869

8. AGE: Years	Months	Days	If less than one day
76	8	21	....hrs. ....min.

9. Birthplace U. S. A.
(Town, county, and state)

10. Usual occupation Teacher

11. Industry or business

FATHER 12. Name Peter Klein
13. Birthplace Germany

MOTHER 14. Maiden name Hilda Jarde Brall
15. Birthplace Germany

16. Informant Hosp. Records
Address Commerce & Market Sts.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/12/45 (month) (day) (year)
Cemetery or crematory Mt. Riddle
Location Near Philadelphia Pa.

18. Funeral director Pennington & Son
Address Havre de Grace Md.

19. Dec 11 1945 (Date rec'd by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1945, at 12:14 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Dec 10 1945
and that I last saw h alive on Dec 10 1945

Immediate cause of death	DURATION
Cirtosis Pulmonis	
Cerebral Hemorrhage	
Due to Natural Progression of Illness	
Due to	
Other conditions Contributed	

(Include pregnancy within 3 months of death)

Major findings at operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clarence Foley M.D.
M. D. or other
Address Havre de Grace Md. Date signed 12/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122a)

CERTIFICATE OF DEATH

12395

Reg. Dist. No. 180

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen Proving Ground
(If outside city or town limits, write RURAL and give nearest town)

How long in above place at death? 1 Dec. 45 to 16 dec. 45

Hospital, institution, or street address where death occurred:
Station Hospital, A.P.G., Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Kansas County:

City or town: Junction
(If outside city or town limits, write RURAL and give nearest town)

Street No. 135 E. 16th
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Odean E. Lee T/Sgt., ASN 6793087

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hazelle Lee

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July, 29, 1904

8. AGE: Years	Months	Days	If less than one day
41	4	17	hrs. min.

9. Birthplace: Sacred Heart, Minn.
(Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business:

FATHER 12. Name: Unknown

13. Birthplace:

MOTHER 14. Maiden name: Unknown

15. Birthplace:

16. Informant: U.S. Army Records

Address: Aberdeen Proving Ground Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Dec 18 1945 (month) (day) (year)

Cemetery or crematory: Sawtell Funeral Home

Location: Junction City, Kansas

18. Funeral director: Howard K. McConnaughey

Address: Abingdon Md

19. Dec. 17 1945 (Date rec'd by registrar) Marie M. Mauldin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 December 1945 at 0920 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 December 1945 to 16 December 1945 and that I last saw him alive on 0920 hrs. 16 December 1945

Immediate cause of death	DURATION
Embolism, pulmonary artery, post-operative.	
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Hernia, left, indirect, complete, reducible, non-strangulated

Cause undetermined. Date of op. 3 Dec 45

Autopsy results: Embolus in right main branch of pulmonary artery

PHYSICIAN: Please underline the cause to which death should be charged principally.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Thomas S. Harvey, M.D.

23. SIGNATURE: THOMAS S. HARVEY, MD M. D. or other

Address: Edgewood Arsenal, Maryland Date signed: 17 Dec 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

COPY SENT TO LOCAL REGISTRAR No. ____ DATE 12/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 1239680

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford County
City or town: Lee Village, Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Ohio County:
City or town: East Liverpool, Ohio
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1213 St. Claire Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: James E. Marlier

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Mary Blake Marlier
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 9, 1920

8. AGE: Years	Months	Days	If less than one day
25	8	23	hrs. min.

9. Birthplace: Follansbee W Va
(Town, county, and state)
10. Usual occupation: Student
11. Industry or business: U.S. army
FATHER 12. Name: Victor E. Marlier
13. Birthplace: Penna
MOTHER 14. Maiden name: Ethel E. Reese
15. Birthplace: Wales
16. Informant: Victor E. Marlier
Address: Follansbee W. Va
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec 5, 1945 (month) (day) (year)
Cemetery or crematory: Roy James Funeral Director
Location: Follansbee W. Va
18. Funeral director: Howard E. McCumstern
Address: Abingdon Maryland
19. Dec. 6 (Date rec'd by registrar) 19 1945 Marie M. Mordale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 19 45 1st reclosure M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute myocarditis, etiology undetermined pending microscopic examination. Acute pulmonary congestion & edema	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Acute myocarditis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E P Komes M.D. M. D. or other
Address: Station Hospital Aberdeen Proving Ground, Md. Date signed: 12/4/45

12397

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Fallston (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Fallston (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Margaret Riley McComas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: Gabriel Jordan McComas
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb 8 1867

8. AGE:

Years	Months	Days	If less than one day
78	11	20	hrs. ____ min.

9. Birthplace: Upper X Roads Harford Co Md
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:
FATHER 12. Name: John B. Curry
13. Birthplace: Harford Co Md.
MOTHER 14. Maiden name: Sarah Ellen Riley
15. Birthplace: Upper X Roads Harford Co Md
16. Informant: Ross McComas
Address: Fallston Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31 45 (month) (day) (year)
Cemetery or crematory: Friends Meeting House
Location: Fallston Harford Co Md.
18. Funeral director: Martin E Hunt
Address: Jarrettsville Md.
19. 12/29 1945 (Date rec'd by registrar) Priscilla Fawood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 1945 at 12:57 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 6 1936 to Dec. 28 1945
and that I last saw h[illegible] alive on December 27 1945

Immediate cause of death	DURATION
Bronchopneumonia	24 hrs.
Due to	
Due to	
Other conditions: Hypertensive Cardiovascular disease	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford F. Hudson M.D.
M. D. or other
Address: Fork Md. Date signed 12/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73d)

CERTIFICATE OF DEATH

12398

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Harve de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Carsons Run - Aberdeen, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt. #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Zachariah Taylor Monk

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
About 82			..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Charles Monk
13. Birthplace: Virginia
MOTHER 14. Maiden name: Josephine Lidden
15. Birthplace: Virginia
16. Informant: L. A. Monk
Address: Aberdeen R#1
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/9/45 (month) (day) (year)
Cemetery or crematory: Mountain Cem.
Location: Near Bel Air, Md.
18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.
19. Dec. 8 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 7 1945, at 1:40 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4 1945, to Dec 7 1945
and that I last saw him alive on Dec 6 1945

	DURATION
Immediate cause of death: Uremia.	4 days
Due to: Chronic arterial C.V.D.	2
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Rapley Hopkins M.D. or other
Address: Elkton, Md. Date signed: Dec 7

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12399

Reg. Diat. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Rural Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edgewood Harford Co

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Allen Lee Murphy

3.(b) Social Security Number: 218-10-8318

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Ida V. Kennard

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Sept. 9 - 1895

8. AGE:

Years	Months	Days	If less than one day
50	3		hrs. min.

9. Birthplace: Harford Co. Md. (Town, county, and state)

10. Usual occupation: Truck Driver Aberdeen

11. Industry or business: Logging Ground

FATHER

12. Name: John Banks

13. Birthplace: Harford Co Md.

MOTHER

14. Maiden name: Mary Lee Murphy

15. Birthplace: Harford Co Md

16. Informant: Mrs. Ida V. Murphy

Address: Aberdeen Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 15 1945 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: Near Aberdeen Md

18. Funeral director: Henry Fanning Sons

Address: Aberdeen Md

19. Dec. 15 1945 (Date rec'd by registrar) Nellie L. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10 1945 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: carbon monoxide poisoning

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 12/10/45

Where did injury occur? Harvide Tree Harford Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Automobile

Means of injury: Collapsed in car Injured at work? no

23. SIGNATURE: Gerald C Palmer M D Deputy Medical Examiner

M. D. or other

Address: Harford County Md. Date signed: 12/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

12400

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 hrs 2 min.

Hospital, Institution, or street address where death occurred:

Harford Memorial Hosp.

How long in hospital or institution? 9 hrs 2 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 812 Market St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ingrid Claydette Nelson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 10, 1943

8. AGE: Years | Months | Days | If less than one day: 9 hrs. 2 min.

9. Birthplace Havre de Grace - Harford Co., Md.

(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Floyd Stanley Nelson

13. Birthplace North Dakota

MOTHER 14. Maiden name Mary Rosine Cruz

15. Birthplace Puerto Rico

16. Informant Mary L. Nelson - Mother

Address 812 Market St - Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/12/43 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace

18. Funeral director Cunningham & Son

Address Havre de Grace

19. Dec. 13 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1945, to Dec 11 1945 and that I last saw h. alive on 12-11-45 1945

Immediate cause of death	DURATION
(a) Premature	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. L. Lewis M.D. M. D. or other

Address Havre de Grace Md Date signed 12-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (28)

CERTIFICATE OF DEATH

12401

★ Reg. Dist. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 New County Road

(If rural, give LOCATION)

2.(a) If veteran, name war: World War #1

3.(a) FULL NAME: Charles Warren Bond

3.(b) Social Security Number: 220-20-7903

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband/wife: Edna M. Bach

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Sept. 15-1892

8. AGE: Years	Months	Days	If less than one day
53	2	22	...hrs. ...min.

9. Birthplace: Vermont (Town, county, and state)

10. Usual occupation: Clerk - Caretaker

11. Industry or business: U.S. Gov. Edgewood Arsenal

FATHER — 12. Name: Linus Bond

FATHER — 13. Birthplace: England

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Ireland

16. Informant: Mrs. Edna M. Bond

Address: 20 New County Road Aberdeen Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 7-1945 (month) (day) (year)

Cemetery or crematory: Bakers

Location: Aberdeen Md.

18. Funeral director: Henry Tagring Sons

Address: Aberdeen Md.

19. Dec 7 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4 1945, at 5 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Acute pancreatitis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Gerald C Palmer M.D. Resident Physician Harford County M. D. or other

Address: B.C.A. Aberdeen Md. Date signed: 12/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

12402

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Harford

City or town Joppa

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? enroute

Hospital, institution, or street address where death occurred:

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Tennessee County

City or town Gallatin

(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 West Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war World War II

3. (a) FULL NAME Charles Edward Robbins

3. (b) Social Security Number Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/29/14

8. AGE:

Years	Months	Days	If less than one day
31	1	23	hrs. min.

9. Birthplace Gordonsville, Tennessee
(Town, county, and state)

10. Usual occupation Dental Officer

11. Industry or business U. S. NAVY

FATHER

12. Name C. D. Robbins

13. Birthplace Gallatin, Tennessee

MOTHER

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Health Record

Address U.S.N.T.C. Bainbridge, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec 23, 1945 (month) (day) (year)

Cemetery or crematory

Location Lo, Gallatin, Tenn.

18. Funeral director Lee A. Patterson & Son

Address Perryville, Md.

19. Dec. 23 1945 Irma E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1945 at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Fracture skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy result Rupture, Traumatic, rt. ventricle

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12/22/45

Where did injury occur? Joppa (City or town) Harford (County) md (State)

Injured at home, farm, industry, public place (where?) U S Route 40

Means of injury Hit truck Injured at work? no

23. SIGNATURE Gerald C Palmer M D
DEPUTY MEDICAL EXAMINER
M. D. or other

Address Rd 4 HARFORD COUNTY Date signed 12/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

12403

Reg. Dist. No. 184 (182)

1. PLACE OF DEATH:
County: Harford
City or town: Dublin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Dublin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Lydia Louisa Rockey

3. (b) Social Security Number: No

4. Sex: Female
5. Color or race: White
6. (a) If single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Charles F. Rockey
Dead
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 11, 1875

8. AGE: Years: 70 Months: 8 Days: 24 If less than one day: hrs. min.

9. Birthplace: Harford Co., Md (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: At Home

FATHER
12. Name: Oliver S. Foard
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden name: Mary R. Harkins
15. Birthplace: Harford Co. Md

16. Informant: Mr. Eugene Rockey
Address: Street, Md. Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 20 1945 (month) (day) (year)
Cemetery or crematory: Dublin M. Cem.
Location: Harford Co. Md.

18. Funeral director: H. S. Bailey
Address: Darlington Md.

19. Dec. 18, 1945 (Date rec'd by registrar) M. A. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 17 1945, at 3 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Dec 17 1945 and that I last saw h[illegible] alive on Dec 17 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 mo
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F C Snodgrass M. D. or other
Address: Darlington Date signed: 12/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

12404 184

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Chestnut Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Chestnut Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Lydia A. Rogers

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John Rogers

6.(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1870

8. AGE:

Years	Months	Days	If less than one day
75	2	25	hrs. min.

9. Birthplace: Harford Co. Md.

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at Home

FATHER

12. Name: Wesley Whitaker

13. Birthplace: Harford Co. Md.

MOTHER

14. Maiden name: Josephine Blake

15. Birthplace: Harford Co. Md

16. Informant: Mrs. Bertha Carr

Address: Darlington, Md. Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 16 1945 (month) (day) (year)

Cemetery or crematory: Centre Cem.

Location: Harford Co. Md.

18. Funeral director: H. S. Bailey

Address: Darlington Md.

19. Dec. 14 1945 (Date rec'd by registrar) M. H. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 13 19 45 at 9 6 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 10 19 45 to Dec 13 19 45

and that I last saw h e alive on Dec 12 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 Days
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F. P. Snodgrass M. D. or other

Address: Darlington Md. Date signed 12/13/45

Harford Rd. Fork — 12405

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33)

CERTIFICATE OF DEATH

Hudson

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Pleasantville Md
City or town Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford County
City or town .....
(If outside city or town limits, write RURAL and give nearest town)
Street No. Pleasantville Md —
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Michael Edward Rahll

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) ~~Single, married, widowed, or divorced~~
M	W	W.

6. (b) Name of husband or wife Mary Francis Roach — 6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 3 1871

8. AGE:

Years	Months	Days	If less than one day
74	1	17	..... hrs. ..... min.

9. Birthplace Fallston (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name George Rahll
13. Birthplace Harford County

MOTHER
14. Maiden name Mary Miller
15. Birthplace Harford County

16. Informant Mrs. Edward Rahll
Address Pleasantville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 24 '45 (month) (day) (year)
Cemetery or crematory St. Johns Cemetery
Location Hydes.

18. Funeral director Leonard Neal
Address 5305 Harford Road

19. 12/22 19 45 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 19 45 at 2:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 5, 19 45, to Dec. 20, 19 45
and that I last saw h— alive on Dec 19 19 45

	DURATION
Immediate cause of death Congestive Heart Failure	5 Days
Due to Influenza	2 Wks.
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations .....
..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Clifford F. Hudson M.D.
M. D. or other
Address Fork Md. Date signed 12/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12406

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Harford Co Home
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Harford Co Home, Bel Air (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Horace Smith

3.(b) Social Security Number

4. Sex: M

5. Color or race: Col

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1855

8. AGE: Years: 90 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Fallston (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Edmund R Scarborough
Address: Fallston, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 8 /48 (mouth) (day) (year)
Cemetery or crematory: Lakemont
Location: Benson

16. Funeral director: Dean & Sallee
Address: Bel Air Md

19. 12-6 1948 Priscilla Fawcett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 6 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11, 1943, to Dec 6 1948
and that I last saw h... alive on Dec 6 1948

Immediate cause of death	DURATION
Coronary Thrombosis	1/2 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clifford E. Hudson M.D.
M. D. or other
Address: Fork Md Date signed: 12/6/48

Supplee

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

★ 124017 Reg. Dist. No. 180

M

I

VS A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Harford
City or town Bel Camp Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Bel Camp Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Josephine Supisic

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Albert Supisic
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 2 1861

8. AGE: Years	Months	Days	If less than one day
84	7	1	..... hrs. ..... min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Joseph Sress
FATHER 13. Birthplace Czechoslovaki
MOTHER 14. Maiden name Katherine Kubes
MOTHER 15. Birthplace Czechoslovaki
16. Informant Mrs Albert Jersey
Address Bel Camp Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 6, 1945 (month) (day) (year)
Cemetery or crematory St. Frances
Location Abingdon Maryland
18. Funeral director Howard R. McCormick
Address Abingdon Md
19. Dec 6 1945 (Date rec'd by registrar) Marie M. Mondale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1945, at 11: A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1942 to Dec 1945 and that I last saw h[illegible] alive on Dec 1 1945

Immediate cause of death	DURATION
Acute Pulmonary edema	3 hrs
Due to Arteriosclerotic Cardiac Disease	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE J. Ralph Hodgson M.D.
M. D. or other
Address Churchville Date signed Dec 5

Evidence for addition of approximate age of deceased is shown on FILM No. I 0 0 JAN 11 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

12408 Reg. Dist. No. 18 1

1. PLACE OF DEATH:
County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Grant
City or town Route Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war Unknown

3.(a) FULL NAME Thurn Thomas

3.(b) Social Security Number 217-07-9676

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Unknown

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE:	Years	Months	Days	If less than one day
Unknown	50			hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Day Laborer
11. Industry or business Powder Yard
FATHER 12. Name Unknown
FATHER 13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace Unknown
16. Informant Mrs Curtis Morgan
Address Aberdeen Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 26-1945 (month) (day) (year)
Cemetery or crematory Mt Calvary
Location Near Aberdeen
18. Funeral director Emory Fanning Jones
Address Aberdeen Md
19. Dec 26 1945 (Date rec'd by registrar) Nellie F Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1945 at 10A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gerald C Palmer M D
DEPUTY MEDICAL EXAMINER M. D. or other
Address R 2 HARFORD COUNTY Date signed 12/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

12409

Reg. Diat. No. 185

1. PLACE OF DEATH: Harford

County ..... Bel Air

City or town .....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred: Gordon St.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Harford

City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)

Street No. Gordon St.
(If rnral, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Blanche Emma Trundle

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife James C. Trundle

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 8, 1883

8. AGE:

Years	Months	Days	If less than one day
62	7	17	..... hrs. ..... min.

9. Birthplace Harford Co Md.
(Town, county, and state)

10. Usual occupation .....

11. Industry or business Home Duties

FATHER
12. Name Wm Griffin
13. Birthplace Md.

MOTHER
14. Maiden name Martha McCommas
15. Birthplace Md.

16. Informant Mrs. Alberta Lloyd
Address Bel Air. Md.

17. Burial Date thereof Dec 28, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rock Spring

Location Harford Co Md.

18. Funeral director Madison Mitchell

Address Havre de Grace, Md.

19. Dec. 28 1945 A. F. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1945, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 16 1945, to Dec 25 1945 xs

and that I last saw h.. alive on Dec 24 1945

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please nnderline the canse to which death shonld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE P M Hopkins M. D. or other

Address Bel Air Md Date signed 12/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

12410

CERTIFICATE OF DEATH

Reg. Diat. No. 188

1. PLACE OF DEATH:
County Harford
City or town Joppa
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Joppa
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frederick Moses Turner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27 1892

8. AGE: Years 53 | Months 3 | Days 12 | If less than one day hrs. min.

9. Birthplace Magnolia, Harford, Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Fred Turner
13. Birthplace Magnolia Md

MOTHER 14. Maiden name Wilhelmina Downey
15. Birthplace Joppa Md

16. Informant Leroy B. Turner
Address Joppa Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 24, 1945 (month) (day) (year)
Cemetery or crematory Abingdon Methodist Cemetery
Location Abingdon Maryland
18. Funeral director Howard K. McComas
Address Abingdon Maryland

19. Dec. 22 1945 (Date rec'd by registrar) Marie M. Woodsdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1945 at 10P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemiplegia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gerald C Palmer MD
Deputy Medical Examiner
Harford County M. D. or other
Address Bel Air Md Date signed 12/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12411

Reg. Dist. No. 184

1. PLACE OF DEATH:
County Harford
City or town Dublin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Dublin
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME John Hyde Walker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6.(b) Name of husband or wife Emma D. Walker
alive 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 9 1895

8. AGE: Years	Months	Days	If less than one day
50	4		..... hrs. ..... min.

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual occupation Store Keeper
11. Industry or business Edgewood Arsenal

FATHER
12. Name Jessie Walker
13. Birthplace Harford Co. Md

MOTHER
14. Maiden name Catherine Cockran
15. Birthplace Harford Co. Md

16. Informant Mrs Emma D. Walker
Address Street, Md. Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 15 1945 (month) (day) (year)
Cemetery or crematory Darlington Cem
Location Harford Co. Md.

18. Funeral director H. D. Bailey
Address Darlington, Md.

19. Dec 9 1945 (Date rec'd by registrar) M. A. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1945 at 6 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 8 1945, to Dec 8 1945
and that I last saw him alive on Dec 8 1945

	DURATION
Immediate cause of death Coronary Thrombosis	4 hrs.
Due to ✓	
Due to ✓	
Other conditions ✓	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ✓ Date of
Where did injury occur? ✓ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ✓ Injured at work?

23. SIGNATURE L. P. Snodgrass M. D. or other
Address Darlington Md. Date signed 12/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

12895

Reg. Dist. No. 184 82

1. PLACE OF DEATH:
County: Harford
~~City or~~ town: Dublin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
~~City or~~ town: Dublin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) No
2.(a) If veteran, name war

3.(a) FULL NAME: James Silas White

3.(b) Social Security Number: No

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Julia A White
6.(c) If alive, give age: Alive ... years
7. Birth date of deceased (mo., day, yr.): Nov. 19, 1883
8. AGE: Years: 62 Months: 1 Days: 11 If less than one day: ... hrs. ... min.
9. Birthplace: Harford Co., Md. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Housework
FATHER 12. Name: Samuel White
FATHER 13. Birthplace: Harford Co. Md.
MOTHER 14. Maiden name: Mary Lilly
MOTHER 15. Birthplace: Harford Co. Md.
16. Informant: Mr. James White
Address: Street, Md., Jan 4 1946
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 8 1946 (month) (day) (year)
Cemetery or: Dublin Cem.
Location: Harford Co. Md.
18. Funeral director: F. D. Bailey
Address: Darlington Md.
19. Jan 12 46 (Date rec'd by registrar) M. McKirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31 19 45 at 11 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 19 45, to Dec 31 19 45
and that I last saw he alive on Dec 30 19 45
Immediate cause of death: Chronic myocarditis — DURATION: 2 yrs
Due to: ✓
Due to: ✓
Other conditions: ✓
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. P. Sweetgrass M. D. or other
Address: Darlington Md. Date signed: 1/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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